8-1-1985

Mississippi Public Health Nurses' Attitudes And Knowledge About Adolescent Sexuality

Charlotte Peavie

Mississippi Public Health Nurses' Attitudes and Knowledge About Adolescent Sexuality

by

Charlotte Peavie

A Thesis
Submitted to the Faculty of
Mississippi University for Women
in Partial Fulfillment of the Requirements
for the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women

August, 1985

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

Mississippi Public Health Nurses' Attitudes

and Knowledge About Adolescent Sexuality

by

Charlotte Peavie

Mary Patricia Curtis
Assistant Professor of Nursing
Director of Thesis

Phyllis W. Werner
Professor of Nursing
Member of Committee

Raymond Skinner
Associate Professor of Nursing
Member of Committee

Ralph E. Hill
Director of the Graduate School

Acknowledgments

Sincere appreciation is extended to my advisor, Mari Pat Curtis, and to Dr. Phyllis Werner, Director of the Graduate Nursing Program at Mississippi University for Women, for their support and guidance during the completion of this thesis;

To my parents, Charles and Annie Lee Howard, for their never-ending faith and encouragement;

And most of all, to my loving husband, Robert, for always being available to share my frustrations; for listening and caring; and without whose love, understanding and support my goal could not have been accomplished.

Abstract

This descriptive study was designed to determine the need for education about adolescent sexuality for public health nurses (PHNs) in Mississippi. Two null hypothesis were stated. Hypothesis I stated that when the nurses' levels of education and attitude scores on the Adolescent Knowledge and Attitude Questionnaire were correlated, there would be no significant correlations at the .05 level. Hypothesis II stated that when the nurses' levels of education and knowledge scores on the Adolescent Knowledge and Attitude Questionnaire were correlated, there would be no significant correlations at the .05 level.

Data were collected from 139 subjects who completed the Adolescent Knowledge and Attitude Questionnaire. The nurses' scores on the survey were correlated with their levels of education utilizing the Biserial Correlation coefficient at the .05 level of significance.

The results demonstrated no significant correlation between the educational levels and the attitude scores; however, there were significant correlations between diploma and associate degree levels and knowledge scores. Therefore, the researcher failed to reject null Hypothesis I and rejected Hypothesis II.

Table of Contents

List of Tables

Chapter I

The Research Problem

Some of the most difficult decisions in life, including those dealing with human sexuality, are made during the teen years (Dacey, 1979). Embarrassment and uncertainty about a newly developing sexuality might result in uninformed decision-making by adolescents. Research has shown the teen pregnancies and its consequences, social and emotional stresses, and sexually transmitted diseases are among the most serious problems resulting from uninformed sexuality decision-making (Smith, 1984).

Adolescent pregnancy continues to be a matter of great concern. One in every 10 teen-age girls becomes pregnant each year. Most teen-age pregnancies are unplanned and result in out-of-wedlock births, abortions, financial problems, and hasty marriages (Smith, 1984).

The incidence of teen-age pregnancy continues to rise. There were one million adolescent pregnancies in 1974. That number increased by 100,000 in 1978. If this pattern continues, 4 in 10 young women will get pregnant at least once while still in their teens (Alan Guttmacher Institute, 1981).

The teen birth rate in Mississippi is ranked as one of the three highest percentages in the nation (Barnett, 1984). Nine thousand, four hundred forty-six babies were born to Mississippi teen-agers in 1983. This was 21.5% of all Mississippi births. The national percentage of births to teens was 14.8% in 1981 (Mississippi State Department of Health, Public Health Statistics, 1984).

Studies show that many teen-age girls do not use contraceptives because of the lack of information available to them. Many believe that for them, pregnancy is impossible, especially as a result of the first sexual experience (Bradshaw, Wolfe, Wood, & Tyler, 1977; Dacey, 1979).

A high rate of maternal mortality is an unfortunate consequence of teen-age pregnancies. Data from New York State for 1975-1978 indicated that adolescent mothers were 92% more likely to have anemia, 15% more likely to suffer from toxemia, and 23% more likely to suffer from complications of premature births. The maternal death rate of mothers under age 15 in 1977-1978 was 2 1/2 times the rate among mothers aged 20-24 (Alan Guttmacher Institute, 1981).

Low birth rate is a major cause of infant mortality. Approximately two thirds of all infant deaths occur in infants who are born weighing less than 5.5 pounds. Teen-age mothers are twice as likely to have low birth weight babies than other women. This might be because

adolescents are less likely to have balanced diets and regular prenatal check-ups (Congressional Research Service, 1984).

Many adolescents feel stressed by family relationships and difficulties in dealing with peer pressure. They have a need to promote self-esteem, to accommodate peer pressure, to experience mutual caring, to feel grown up, and sometimes, to get even. These are some of the reasons why adolescents want to be sexually active (Hill & Ricks, 1984).

Once the decision has been made, consciously or unconsciously, to become sexually active, the adolescent might not prepare for safe intercourse. For some teens, preparing for intercourse would be an unwanted admission of a desire for sexual activity. Teens with negative feelings about sex, especially girls, would rather take their chances without protection. A guilty or otherwise negative self-image by other adolescents might prevent them from feeling that they deserve to be protected from the tragedy of an unplanned pregnancy (Dacey, 1979).

Interruption of education is an unfortunate consequence of many childbearing adolescents. The majority of young teenage mothers never obtain even a high school diploma. Because of educational deficits, opportunities to gain skills needed to compete in and contribute to society are limited (Alan Guttmacher Institute, 1981).

A lack of education and skills leaves teen-age parents unable to get decent jobs. Their incomes tend to be much lower than those of other families. In 1975, the mean family income of white women who gave birth at or before age 16 was $7,550. This was about half of what was earned by families in which the mother delayed birth until her middle to late 20s. Insufficient income leaves many teen-age parents dependent on public welfare for support (Alan Guttmacher Institute, 1981).

Among teen-age parents who marry, separation or divorce is two times more likely to occur than among those who wait until their 20s to become parents. Forty-four percent of women who gave birth at ages 14 to 17 have disrupted marriages within 15 years. This is three times the proportion among women who postponed childbearing until age 20 or later (Alan Guttmacher Institute, 1981).

Social and emotional stresses caused by teen-age pregnancy can lead to suicide. Suicide is the third leading cause of death to adolescents. This alarming evidence shows the need for attention and support in this age group (Igoe, 1980).

The spread of sexually transmitted diseases (STDs) has reached almost epidemic proportions in the United States. The rate of rise in STDs has been more rapid among the adolescent age group than among the population as a whole. The current incidence of gonorrhea among 15- to 19-year-olds

is second only to that of 20- to 24-year-olds. This may also be true of the incidence of chlamydial infections and herpes as well (Smith, 1984).

Research suggests that knowledge of sexuality encourages more responsible behavior as well as more tolerant sexual attitudes, yet less than 10% of today's adolescents receive a comprehensive sex education program (Maslach & Kerr, 1983). Teens receive most of their information about sex from their peers. This information is usually filled with misconceptions (Onyehalu, 1983).

Nine out of 10 parents believe that young people should be educated about sexuality. Many parents believe that such courses should be taught in the schools. Many others who are willing to discuss sex with their teens are unable to provide accurate information (Alan Guttmacher Institute, 1981).

Only three states in the nation require sex education in the schools despite the public approval of this course. Only seven other states encourage it. Mississippi is among 19 states which have no policy at all dealing with sex education in the schools (Alan Guttmacher Institute, 1981).

Adolescent counseling in human sexuality is an important component of health care delivery. Nurses, because of their frequent and lengthy client contacts in the community, may be better able to establish the trusting relationship needed to do sexual counseling than many other

health professionals (Zalar, 1982). The unfortunate problems described in the preceding paragraphs can be avoided or controlled through effective sexual counseling (Onyehalu, 1983; Smith, 1984).

Nurses who do not possess adequate knowledge and attitudes regarding adolescent sexuality may not be able to effectively counsel these clients about human sexuality. "In addition to possible mismanagement of patients when attitudes interfere with objective listening or dispassionate management, strong feelings and prejudicial attitudes interfere with the acquisition of knowledge, and biases or inadequate knowledge may well interfere with the development of skills" (Lief & Payne, 1975, p. 2026).

Although nurses seem to be the ideal health care professionals to provide sexuality counseling to adolescents, many have operated from a narrow base of knowledge and with conservative, judgmental attitudes. These nurses have not been able to adequately deal with the sexuality concerns of their clients (Mims, 1975).

This researcher, through experience as a Mississippi community health nurse-consultant and Family Nurse Clinician (FNC) student, has noticed that very little adolescent sexual counseling is done by Mississippi public health nurses (PHNs). This observation initiated the researcher's interest in the interpersonal relationships of PHNs and adolescents. An increased awareness of the knowledge and

attitudes of PHNs will enable the researcher to assist PHNs in their efforts to establish effective interpersonal relationships with adolescent clients.

The FNC works closely with other nurses in providing comprehensive health care. Educating other nurses to facilitate optimal care is a part of the expanded role of the FNC. With a better understanding of the knowledge and attitudes of PHNs about adolescent sexuality, the FNC would be aware of the educational needs of the PHNs and could offer assistance. However, the researcher recognizes that to solve the lack of adequate adolescent sexuality counseling, further investigation would be required into the counseling techniques of PHNs.

The purpose of this study was to survey the attitudes and knowledge of Mississippi PHNs about adolescent sexuality. The questions to be answered by this study were:

1. What are the attitudes and knowledge of Mississippi public health nurses about adolescent sexuality?

2. Does the level of education influence the knowledge and attitudes of Mississippi public health nurses about adolescent sexuality?

Chapter II

Theoretical Basis of the Study

King's conceptual framework of goal attainment is the theoretical basis for this study of Mississippi public health nurses (PHNs) background knowledge and attitudes about adolescent sexuality. Negative attitudes and limited knowledge can negatively affect the quality of PHNs' interactions with this age group and lead to ineffective sexuality counseling. Family Nurse Clinicians (FNCs) can assist PHNs to prevent poor quality nurse-adolescent interactions and thus maintain health in communities. The FNC can assess the background knowledge and attitudes of PHNs about adolescent sexuality to determine the need for education and training. The following concepts from King's (1971) theory of attainment provide the basis for this research.

Assisting individuals and groups in society to attain, maintain, and restore health is, according to King (1971), accomplished by nurses in the performance of their roles and responsibilities. Thus, the PHN is fulfilling the roles and responsibilities of a nurse, according to King, by counseling adolescents about sexuality which contributes to adolescents' total health maintenance programs. One of the

processes by which nurses fulfill their roles and responsibilities is through the development of interpersonal relationships in which information is shared and data is collected. The development of such relationships is based on perceptions which influence behavior, life, and health (George, 1980). King (1971) defines an interpersonal relationship as "the interaction of two or more individuals . . . in time for some purpose or goal" (p. 23) and perception as "each individual's . . . image of reality; an awareness of objects, persons, and events" (p. 22). Perceptions may be influenced by situational stress causing limited or false information sharing in interpersonal relationships (King, 1983). Thus, in order to maintain adolescent health through effective sexual counseling, PHNs need to establish interpersonal relationships with their adolescent clients leading to accurate and complete information sharing.

However, PHNs who have negative attitudes and/or a lack of knowledge about adolescent sexuality may be perceived by their adolescent clients as uncaring, uncomfortable, and unaware of the problems teen-agers face. The adolescents' perception of the PHN can create situational stress in their interpersonal relationship which can influence the amount and accuracy of information shared. Inaccurate and/or incomplete data collection results from this type of relationship and leads to ineffective counseling. Thus, the

PHN is not fulfilling her roles and responsibilities in attaining, maintaining, or restoring health to adolescents.

King identifies three phases of behavior of interacting persons that occur during the act of nursing. Phase I is the recognition of presenting conditions. In this phase, nurses interact with clients, other professionals, or family members to systematically gather information about past events and current signs and symptoms. Phase II involves the operations or activities related to the conditions or situations assessed in Phase I. The nursing act in Phase II is the use of knowledge and skills to help individuals and groups cope with problems and learn ways of adjusting to changes. The motivation to exert some control over events to achieve goals is the third phase of the nursing act. Nurses must be willing to guide, support, offer assistance, and evaluate the events and processes leading to goal attainment (King, 1971; King, 1981).

Phase I, the recognition of presenting conditions (King, 1971), is the phase which this research is testing. Phase I is accomplished by data collection and data analysis. Before FNCs can assist PHNs in establishing effective interpersonal relationships with adolescent clients for sexual counseling, the attitudes and knowledge levels of PHNs must be assessed.

Chapter III

Hypotheses

Theoretical Hypotheses

1. There is no correlation between level of education and knowledge of adolescent sexuality among public health nurses.

2. There is no correlation between level of education and attitudes of adolescent sexuality among public health nurses.

Definitions

1. Knowledge: facts and information possessed by the public health nurses as evidenced by their responses on the Adolescent Knowledge and Attitude Questionnaire.

2. Adolescent sexuality: the aspect of teen-agers' lives related to sexual activity, self-esteem, and human development.

3. Public health nurses: registered nurses licensed in the State of Mississippi and practicing in Mississippi county health departments.

4. Attitudes: values and beliefs held by the public health nurses as evidenced by their responses on the Adolescent Knowledge and Attitude Questionnaire.

5. Correlation: variances of the scores obtained from the Adolescent Knowledge and Attitude Questionnaire using the Biserial Correlation.

6. Level of education: highest completed academic degree achieved by the subjects.

Operational Hypotheses

1. When registered nurses licensed in Mississippi and practicing in public health departments complete the Adolescent Knowledge and Attitude Questionnaire and the knowledge scores are correlated with levels of education of the subjects, there will be no significant correlation in the knowledge scores of nurses with B.S. or higher academic degrees and the knowledge scores of nurses without B.S. degrees at the .05 level of significance using the Biserial Correlation.

2. When registered nurses licensed in Mississippi and practicing in public health departments complete the Adolescent Knowledge and Attitude Questionnaire and the attitude scores are correlated with levels of education of the subjects, there will be no significant correlation in the attitude scores of nurses with B.S. or higher academic degree and the attitude scores of nurses without B.S. degrees at the .05 level of significance using the Biserial Correlation.

Chapter IV

Review of Literature

Adolescents who base their sexual decisions on inadequate information are subjected to the consequences of teen-age pregnancy and sexually transmitted diseases as well as possible social, emotional, and psychological trauma. These unfortunate consequences can be avoided or controlled through effective sexuality counseling (Onyehalu, 1983; Smith, 1984). Limited research has been done on the effect of knowledge and attitude on the outcome of adolescent sexuality. Research material pertaining to this subject is even more scarce for counseling done by public health nurses. Articles and studies will be reviewed regarding health care providers as adolescent sex counselors, nurses' roles as adolescent sex counselors, factors affecting nursing competency in counseling adolescents about sexuality, and the lack of preparation of nurses to function effectively in this role.

Health Care Providers as Adolescent Sex Counselors

Sexual counseling is not the exclusive province of any given discipline (Schuster, Unsain, & Goodwin, 1982). In

1975, the World Health Organization (WHO) expressed the importance of counseling in human sexuality as a component of health care delivery (Zalar, 1982). The tenth position statement of the Sex Information and Education Council (SIECUS) states, "Sexual health care is a valid concern of the total health care to which everyone is entitled, and therefore provisions must be made for it in health care planning . . . " (Mims, 1975, p. 523). Thus, counseling should be included in the total health care given to adolescents by health care providers.

Research suggests that the behaviors of health care providers and their interactions with patients can affect the outcome of health care, including counseling effectiveness. Strecher (1984) states, "There is substantial evidence that qualities of the interactions between patients and . . . [health care providers] have significant impact on several health related outcomes, including . . . patient learning of relevant information, and satisfaction with various aspects of health care" (p. 129).

Reagan (1981) conducted a study of the interaction of health professionals and a group of their clients with special concerns regarding sexuality. A sample of 39 lesbians was used in this exploratory study. The researcher suggests from the findings that apprehension exists between these clients with special sexuality concerns and their

health care professionals. This apprehension may impair the quality of care. Because of this apparent apprehension, many clients do not discuss their concerns with the health care professionals, or they delay care for problems they are having.

In 1980, Falvo, Woehlke, and Deichmann studied the relationship of two aspects of health care provider behavior to patient acceptance of therapeutic health care. The two behaviors studied were attitudes of acceptance and concern and sharing of knowledge. A 12-item questionnaire on a four-point Likert-type scale was administered to 103 patients at a rural comprehensive health clinic. The researchers suggest that the most influential factors affecting patient acceptance of therapeutic health care were the perceptions of patients in regard to the knowledge and attitude of the health care provider. The more patients perceived the health care provider as knowledgeable and concerned, the greater was acceptance of health care.

Nurses as Adolescent Sex Counselors

It has been established that adolescent sexuality counseling should be done by health care professionals, yet many physicians see teen-agers as difficult, rebellious patients and are reluctant to work with this population. Some physicians avoid counseling young people about sexuality because of a lack of behavioral science skills, others lack adequate time needed to talk with adolescents

(Smith, 1984; Zakus, Cooper, Leff, & Moore, 1980). Zalar (1982) suggests that nurses are the health care providers of choice to provide sexuality counseling to adolescents. The frequent and lengthy contacts nurses have with clients in the community enable them to establish the trusting relationships needed to do sexual counseling. According to Mims (1975), nurses should be able to " . . . integrate sexual health care in relation to mental, social, and physical well-being in preventive, therapeutic, and educational aspects of total health care" (p. 523).

Nurses can play an important role in enhancing an adolescent client's quality of life through effective sex counseling if she/he possesses certain qualities (Zalar, 1982). To reduce anxieties and facilitate effective nurse-client communication, nurses should have knowledge of and be comfortable with discussing homosexuality, abortion, wanted and unwanted pregnancies, sexually-transmitted diseases, contraception, masturbation, sexual myths, and sexual street language. Knowledge of education and psychosocial needs during different periods of sexual growth and development is also necessary to promote decision-making and clarify values in the counseling process (Mims, 1975; Taver, 1983).

The following studies suggest that many nurses are not equipped with the knowledge and attitudes needed to do sexuality counseling and that some additional form of

preparation is needed for them to be effective in this area. Nicholson, Lord, Tibbett, and Borningham (1981) investigated the professional attitudes of registered nurses about human sexuality. The researchers developed a questionnaire and administered it to two groups of registered nurses, 27 community nurses, and 26 hospital nurses. They found that of the total sample, 98% thought they were inadequately prepared to deal with matters related to sexuality.

Lief and Payne (1975) used the Sex Knowledge and Attitude Test (SKAT) to compare two nursing groups with three other groups; 1,774 nursing students, 828 Registered Nurses (RNs), 1,104 female medical students, and 1,243 female college students. They found that the RNs were the most conservative in their attitudes about sexuality. The knowledge scores of the RNs were lower than all except those of the college students.

Luber (1975) used the SKAT tool and the Professional Sexual Role Inventory (PSRI) to study the relationship between sexual knowledge and attitude of nurses. One hundred eight family planning nurses and 67 senior nursing students were the sample. Luber found that nurses over the age of 40, who attended church frequently, who stated they were very religious, and who worked in nonurban areas were less knowledgeable and more conservative. Luber's findings supported her hypothesis that the more knowledge a nurse has

of sexuality, the more favorable her attitude toward sexuality and the greater her ability to deal with clients in sexual situations.

A survey of nursing faculty's knowledge and attitudes about human sexuality was done by Fontaine in 1976. The sample consisted of 124 instructors in the Chicago area. More than 45% of the faculty indicated on the questionnaire that they had a fairly adequate level of understanding of normal sexuality, yet 28.4% indicated that they only sometimes ask routine questions concerning the patient's sexual history. It was indicated that 30.4% of the instructors seldom ask routine sexual history questions, and 29.5% never ask them. From these findings, Fontaine suggests that nursing faculty members have difficulty discussing sexuality with their patients.

Fisher and Levine (1983) administered the SKAT to 120 oncology nurses in Maryland to determine their level of sexual knowledge and their attitudes toward sexuality. The results of the study revealed that the nurses' knowledge scores had not improved, in fact, were significantly lower when compared to the scores of nurses tested in 1972.

Another researcher, de Lemos (1977), reported changes in sexual knowledge and attitudes following a three-day human sexuality workshop. She hypothesized that attitudes toward human sexuality would become more positive and knowledge would increase following the workshop.

Fifty-seven subjects were used in the study. The SKAT was administered before and after the workshop to the experimental group and twice to a control group who did not attend the workshop. The results indicated an increase in the scores of the workshop participants toward the more positive end of the knowledge and attitude scales of the SKAT.

A similar study was done by Robinson (1984) using the SKAT to study the difference in sexual knowledge and attitudes between public health nurses in Mississippi who participated in a human sexuality course and some who did not. There were 80 subjects in the sample. There were significant differences in the knowledge scores and in one subscale of the attitude scores of public health nurses who participated in the study and those who did not. The researcher recommended conduction of similar studies using larger sample sizes, different testing tools, and collecting additional data.

Conclusion

The literature supports the idea that nurses, because of their lengthy and frequent client contacts may be the best health care professionals to counsel adolescents regarding sexuality. The literature also documents that inadequate knowledge and unfavorable attitudes can interfere with the establishment of interpersonal relationships needed for nurses to provide quality health care to adolescents. Nurse-counselors should be prepared to deal with adolescents

and their problems regarding sexuality; therefore, they must become more knowledgeable and more aware of their own attitudes about sex in adolescence.

Chapter V

Research Design and Methodology

Research Approach

The research design that was employed in this research study was descriptive. Polit and Hungler (1983) define descriptive research as "research studies that have as their main objective the accurate portrayal of the characteristics of persons, situations, or groups, and the frequency with which certain phenomena occur" (p. 613). This study was an attempt to accurately portray the attitudes and knowledge of Mississippi public health nurses about adolescent sexuality.

Variables

The dependent variables were the knowledge and attitudes about adolescent sexuality as reflected by the scores of the Adolescent Knowledge and Attitude Questionnaire. The controlled variables were profession and place of employment. The intervening variables included truthfulness in completing the questionnaire, the participants' individual value systems, and recent educational experiences dealing with adolescent sexual counseling.

Selection of Subjects

The setting for this study was the State of Mississippi. The population of Mississippi is 2,520,638. There are 82 counties and 81 main county health departments in this primarily rural state (Mississippi Statistical Abstract, 1984).

The population included 540 full-time nurses in the public health departments of Mississippi representing all levels of education (S. Walters, personal communication, April 10, 1985). The sample consisted of actively practicing public health nurses in Mississippi who were willing to participate in the study. The projected sample size was 100.

Data Gathering Process

The researcher contacted the nursing assistant of the Mississippi State Department of Health and explained the purpose and nature of the study. Written consent was requested (see Appendix A); however, the nursing assistant gave verbal consent only. A list of county health department addresses was obtained at this time. Research packets were prepared which contained a letter of explanation (see Appendix B), a questionnaire (see Appendix C), and a self-addressed stamped envelope. Two packets were mailed to each county health department with instructions for the county coordinating nurse to distribute the questionnaires to two public health nurses in the county. The prospective

participants were requested to return the questionnaire within two weeks. It was explained that return of the questionnaire indicated informed consent. A postcard reminder was mailed to each prospective participant one week after the questionnaires were mailed. The data were collected from May to June, 1985.

Procedure

The tool that was used is a researcher-modified version of the questionnaire, Nurse Attitudes on Sexual Counseling as a Nursing Responsibility. The original tool, developed by Green (cited in Ward & Lindeman, 1975), measures sex attitudes, background in sex education, ability to discuss sex matters with others, and open-mindedness regarding sexual counseling as a nursing responsibility.

The revised questionnaire changed the focus from general human sexuality to adolescent sexuality. The modified questionnaire contains 28 questions. The categories and their content are as follows: (a) Demographic data--questions 1, 2, 3, 5, 7, and 8; (b) Educational background--questions 4 and 6; (c) Sexuality knowledge--questions 13, 15, 17, 19, and 20 through 25; (d) Sexuality attitudes--questions 9 through 12, 14, 15, 18, 26, 27, and 28. Questions 1 through 11 are multiple choice. Questions 12 through 28 are true-false. The highest possible scores are 10 in adolescent sexuality knowledge and 10 in adolescent sexuality attitudes. Scores closer to 10

indicate more liberal sexual attitudes and greater sexual knowledge.

The questionnaire was pretested by five public health nurses who were omitted from the sample. The tool was assumed to have face validity and reliability within the confines of this study. Descriptive statistics were used to describe and analyze, and data collected for Hypotheses I and II. The Biserial Correlation was used to correlate the scores of the questionnaire with levels of education. In this study, the responses of public health nurses of different ages, education, and religious backgrounds were compared.

Assumptions

1. Public health nurses surveyed will answer the questionnaire truthfully.

2. Public health nurses have knowledge and attitudes about sexuality which can be measured.

3. If FNCs were aware of the knowledge and attitudes of public health nurses about adolescent sexuality, they would use the information to improve adolescent sexual counseling.

Limitations

1. The findings of the study will not be generalizable to public health nurses in areas other than Mississippi.

2. Limitation to public health nurses excludes generalization to nurses in hospitals, private clinics, and other areas.

3. The study prevents generalization on knowledge and attitudes of subject matter other than adolescent sexuality.

Chapter VI

Analysis of Data

The purpose of this study was to determine the need for education about adolescent sexuality for public health nurses (PHNs) in Mississippi. Data were collected from subjects who completed a researcher-modified version of the questionnaire, Nurse Attitudes on Sexual Counseling as a Nursing Responsibility, by Green (cited in Ward & Lindeman, 1975). The researcher-modified survey was entitled "Adolescent Knowledge and Attitude Questionnaire." The questionnaire assessed demographic data about PHNs and measured their levels of knowledge and attitudes about adolescent sexuality.

A total of 139 subjects was included in the study. All subjects were Mississippi PHNs. Eight (5.8%) of the subjects were 25 years old or younger, 54 (38.8%) were 26 to 35 years old, 55 (39.6%) were between the ages of 36 and 50, and 22 (15.8%) were 51 years of age or older.

One hundred twenty-eight (91.1%) subjects in this study indicated they were married. Two (1.4%) subjects were never married, 8 (5.8%) were divorced or separated, and 1 (.7%) was widowed. The distribution of childhood religious

backgrounds was 118 (84.9%) Protestants, 11 (7.9%) Catholic, and 10 (7.2%) with other religious backgrounds.

There were 54 (38.8%) diploma degree nurses in the sample. Sixty-one (43.9%) of the subjects had associate degrees, 22 (15.8%) had baccalaureate degrees, and 2 (1.4%) had additional college degrees other than master's degrees. There were no subjects in the sample with master's degrees and only 12 (8.6%) subjects had a human sexuality course in the past two years.

Fifty-three (38.1%) subjects had three years or less of public health nursing experience. Thirty-two (23%) had three to six years of experience, 28 (20.1%) had six to 10 years of experience, and 26 (18.7%) had more than 10 years of experience.

Seven (5%) subjects indicated no specific courses in human sexuality were offered in their basic nursing curricula. Of the remaining 137 subjects, 75 (54%) had had curriculum for normal sexual behavior, 56 (40.3%) had had curriculum for abnormal sexual behavior, 57 (41%) had had curriculum for sexual behavior in relation to disease or physical condition, 55 (39.6%) had had curriculum for basic concepts of sexuality, 72 (51.8%) had had contraception included in their curriculum, and 127 (91.4%) had had curriculum for reproductive processes.

Eight (5.8%) subjects indicated they had never been questioned by adolescents regarding sexual behavior.

Thirty-four (24.5%) were seldom questioned, 46 (33.1%) were sometimes questioned, and 50 (36%) were questioned often. One (.7%) subject never answered adolescents' questions about contraception, 6 (4.3%) seldom answered questions about contraception, 6 (4.3%) seldom answered questions, 15 (10.8%) sometimes answered questions, and 115 (82.7%) often answered them.

The nurses' scores on the Adolescent Knowledge and Attitude Questionnaire ranged from 2 to 9 with a mean of 5.532 on the attitude section and from 3 to 10 with a mean of 7.338 on the knowledge section. The demographic data along with the scores on the survey can be found in Table 1.

Hypotheses

The researcher hypothesized that when the nurses' levels of education and attitude scores on the Adolescent Knowledge and Attitude Questionnaire were correlated, there would be no significant correlation. The researcher also hypothesized that when the nurses' levels of education and knowledge scores were correlated, there would be no significant correlation. The data were correlated using the Biserial Correlation at the .05 level of significance. Correlation of the educational levels and attitude scores revealed r values of -.0781 for diploma degrees, .1023 for associate degrees, -.0062 for baccalaureate degrees, and .0874 for additional college degrees. None of these values were significant; therefore, the researcher failed to reject

Table 1

Raw Subject Data Including Demographic and Test Scores

Subject	Age	M/S	Rel	Edu	HSC	Years	Curriculum	Q	A	Att	Know
1	51 ≥	M	C	D		6-10		SO	O	8	8
2	36-50	M	P	D		3-6	NSB	O	O	8	7
3	36-50	M	P	D		> 10	RP	SO	O	5	7
4	36-50	M	C	D		> 10	RP	S	O	7	8
5	36-50	D/S	P	AC		3-6	NSB C RP	S	SO	9	8
6	36-50	M	P	D		0-3	NSB CS RP	O	O	5	7
7	36-50	M	P	BS		6-10	NSB SBD CS C RP	O	O	8	7
8	26-35	M	P	AD		0-3	NSB ASB SBD CS C RP	SO	O	8	8
9	26-35	M	P	AD		3-6	NSB ASB SBD CS RP	O	O	4	7
10	36-50	M	P	D		3-6	NSB SBD RP	O	O	7	7
11	26-35	M	P	AD		0-3	CS C RP	SO	O	9	6
12	36-50	M	C	D		0-3	C RP	N	O	6	7
13	26-35	M	C	BS		0-3	CS RP	S	O	5	7
14	36-50	M	C	D		6-10	C RP	S	O	7	6
15	26-35	M	P	BS		6-10	RP	O	O	7	8
16	26-35	M	P	AD		6-10	RP	S	S	2	7
17	25 ≤	M	P	BS	X	0-3	NSB ASB SBD CS C RP	SO	O	4	9
18	26-35	M	P	AD		0-3	SBD C RP	SO	O	6	8
19	26-35	M	P	AD		6-10	NSB ASB SBD C RP	O	O	7	9
20	51 ≥	M	P	D		> 10	RP	O	O	5	6
21	26-35	M	P	BS		6-10	NSB ASB SBD CS C RP	S	O	4	8
22	36-50	M	P	D		> 10	NSB ASB SBD C RP	S	O	3	7
23	36-50	M	P	AD		6-10	SBD RP	O	O	6	7
24	26-35	NM	P	D		0-3	SBD RP	O	O	9	9
25	26-35	D/S	P	AD		0-3	NSB ASB C RP	O	O	9	9
26	26-35	M	P	AD		3-6	NSB SBD C RP	SO	O	7	7
27	25 ≤	M	O	AD		0-3		SO	O	3	5
28	36-50	M	P	AD		6-10	CS C RP	SO	O	7	9
29	36-50	M	P	D		> 10	NSB ASB SBD CS C RP	O	O	9	9
30	51 ≥	M	P	AD		3-6	C RP	SO	SO	5	7
31	26-35	M	P	AD		0-3	NSB CS RP	S	O	4	8
32	26-35	M	P	AD		0-3	NSB CS RP	SO	SO	6	9
33	51 ≥	M	P	D		> 10	RP	O	O	3	5
34	36-50	D/S	O	D		> 10	RP	O	O	3	7
35	36-50	NM	P	AD		0-3	NSB ASB SBD CS C RP	S	O	9	9
36	26-35	M	P	D		3-6	NSB ASB CS RP	SO	O	6	8
37	26-35	M	P	AD	X	> 10	NSB ASB SBD CS RP	O	O	2	3
38	51 ≥	M	P	D		3-6	NSB ASB SBD RP	SO	O	2	3
39	25 ≤	M	P	AD		0-3	NSB ASB SBD CS C RP	O	O	8	8

Note. Key for Table 1 (Raw Subject Data).
M/S = Marital Status (M = Married, NM = Never Married, D/S = Divorced or Separated, W = Widowed)
Rel = Religion (C = Catholic, P = Protestant, J = Jewish, O = Other)
Edu = Education (D = Diploma, AD = Associate Degree, BS = Baccalaureate Degree, AC = Additional College other than master's degree, MS = Master's Degree)
HSC = Has had a course in human sexuality in the past two years
Years = Number years of public health nursing experience
Curriculum = Curriculum included in educational program related to human sexuality (NSB = Normal sexual behavior, ASB = Abnormal sexual behavior, SBD = Sexual behavior in relation to disease or physical condition, CS = Concepts of sexuality, C = Contraception, RP = Reproductive Processes)
Q = How often nurse has been questioned by adolescents regarding sexual behavior (N = Never, S = Seldom, SO = Sometimes, O = Often)
A = How often nurse has answered adolescents' questions regarding contraception (N = Never, S = Seldom, SO = Sometimes, O = Often)
Att = Total attitude score
Know = Total knowledge score

Subject	Age	M/S	Rel	Edu	HSC	Years	Curriculum	Q	A	Att	Know
40	51 ≥	M	P	AD		> 10				2	6
41	26-35	M	C	AD		0-3	C RP	SO	O	6	7
42	26-35	M	P	D		6-10	C RP	S	O	4	7
43	36-50	M	P	AD		> 10	RP	SO	SO	3	8
44	26-35	M	O	BS		3-6	NSB CS C RP	O	O	3	8
45	36-50	M	P	D		0-3	NSB ASB SBD CS C RP	O	O	9	7
46	36-50	M	P	D		0-3	NSB ASB SBD CS RP	SO	O	5	8
47	36-50	M	P	D		6-10	RP	SO	O	7	9
48	25 ≤	M	P	AD		0-3	NSB ASB SBD CS C RP	O	O	6	9
49	26-35	M	P	AD		0-3	NSB ASB CS C RP	S	S	9	8
50	51 ≥	M	P	D	X	6-10	SBD	O	O	6	8
51	51 ≥	M	P	D		> 10	RP	O	O	4	6
52	36-50	M	P	AD		0-3	NSB ASB RP	S	O	4	7
53	36-50	M	P	AD		3-6	RP	SO		3	9
54	36-50	M	P	D		6-10	NSB ASB CS C RP	O	O	5	8
55	36-50	M	P	BS		6-10	NSB ASB RP	SO	O	4	9
56	36-50	M	P	BS		0-3		O	O	7	8
57	26-35	M	P	AD		3-6	RP	S	O	6	6
58	36-50	D/S	P	D		0-3	RP	SO	SO	6	9
59	36-50	M	P	AD		0-3	ASB C RP	SO	O	9	8
60	36-50	M	C	D		3-6	NSB RP	S	O	4	5
61	26-35	M	P	BS		3-6	NSB ASB SBD CS C RP	SO	O	4	6
62	36-50	M	P	BS		6-10	C RP	O	O	8	8
63	25 ≤	M	P	AD		0-3	NSB ASB SBD C RP	S	O	8	8
64	51 ≥	M	P	D		> 10	NSB ASB RP	SO	O	7	6
65	36-50	M	P	D		3-6		N	O	8	7
66	26-35	M	P	BS		0-3	NSB ASB SBD CS C RP	S	O	6	8
67	26-35	M	O	BS		0-3	NSB ASB SBD CS C RP	SO	O	6	8
68	36-50	M	C	BS		3-6	RP	O	O	9	9
69	51 ≥	M	O	D		> 10	CS C RP	O	O	6	6
70	36-50	M	P	D	X	> 10	SBD CS	O	O	9	7
71	36-50	M	P	D		3-6	SBD RP	O	O	3	7
72	36-50	M	P	AD		0-3	ASB CS C RP	SO	O	9	8
73	26-35	M	P	D	X	6-10	C RP	O	O	5	7
74	51 ≥	M	P	AD		0-3	NSB ASB RP	SO	O	3	7
75	26-35	M	O	AD		0-3	NSB ASB RP	S	O	3	7
76	36-50	D/S	P	D		0-3		N	S	4	6
77	26-35	M	P	AD		6-10	RP	SO	O	6	9
78	51 ≥	D/S	P	D		0-3	RP	S	S	3	6
79	26-35	M	C	D		0-3	RP	SO	O	3	6
80	26-35	M	P	AD		0-3	NSB ASB C RP	O	O	8	6
81	51 ≥	M	P	D	X	6-10	SBD RP	SO	SO	3	7
82	36-50	M	P	AD		0-3	NSB ASB SBD CS C RP	N	O	7	8
83	36-50	M	P	AD		3-6	NSB ASB SBD C RP	N	O	5	8
84	36-50	M	P	D		3-6	SBD C RP	S	O	8	6
85	26-35	M	O	AD		0-3	NSB ASB SBD CS C RP	SO	SO	8	7
86	26-35	D/S	P	AD		3-6	NSB ASB SBD CS C RP	S	S	4	7
87	51 ≥	M	P	D		> 10	NSB ASB SBD RP	SO	O	7	5
88	26-35	M	P	AD		0-3	ASB SBD CS C RP	O	O	9	8
89	26-35	M	P	AD		6-10	NSB ASB SBD CS C RP	O	O	2	7
90	26-35	M	P	AD		0-3	RP	S	O	4	7
91	25 ≤	M	P	BS		0-3	NSB ASB SBD CS C RP	O	O	8	8
92	36-50	M	P	D		> 10	NSB ASB SBD CS C RP	SO	O	5	8
93	26-35	M	P	AD		0-3	NSB ASB SBD CS C RP	SO	SO	4	7
94	26-35	M	P	AD		0-3	NSB ASB RP	SO	O	3	7

Subject	Age	M/S	Rel	Edu	HSC	Years	Curriculum	Q	A	Att	Know
95	36-50	W	P	D		> 10	RP	SO	O	4	7
96	36-50	M	O	AD		0-3		O	O	7	8
97	51 ≥	M	P	AD		> 10	NSB C RP	O	O	3	9
98	51 ≥	M	P	AD		> 10	NSB C RP	S	O	3	9
99	36-50	M	P	AD		3-6	NSB ASB SBD CS C RP	SO	O	5	8
100	36-50	M	P	D		3-6	NSB ASB SBD CS C RP	N	O	5	6
101	51 ≥	M	P	D		> 10	NSB ASB SBD CS C RP	SO	SO	3	7
102	36-50	M	P	AD	X	6-10	NSB ASB CS RP	O	O	9	8
103	51 ≥	M	P	D		6-10	NSB ASB SBD RP	O	O	6	5
104	36-50	M	P	AD		3-6	C RP	SO	O	6	8
105	26-35	M	P	BS		6-10	SBD RP	SO	O	5	10
106	26-35	M	P	D		0-3	SBD CS C RP	S	SO	5	7
107	36-50	M	O	AD	X	6-10	NSB ASB SBD CS C RP	SO	O	9	7
108	26-35	M	P	AD		3-6	CS C RP	S	SO	8	9
109	36-50	M	P	AC		0-3	NSB ASB RP	N	N	5	5
110	26-35	M	P	AD		6-10	NSB ASB SBD CS C RP	O	O	6	7
111	26-35	M	P	D		3-6	NSB C RP	S	SO	5	8
112	36-50	M	P	AD		6-10	SBD CS C RP	SO	O	3	8
113	51 ≥	M	P	D		> 10	C RP	SO	SO	4	6
114	36-50	M	P	D		> 10	NSB SBD CS C RP	O	O	3	8
115	36-50	M	P	D	X	> 10	NSB	SO	O	6	8
116	26-35	M	C	AD		6-10	C RP	O	O	5	7
117	36-50	M	P	BS		3-6	RP	O	O	4	7
118	26-35	M	P	D		0-3	NSB SBD CS C RP	O	O	8	8
119	26-35	M	P	D		3-6	C RP	SO	O	3	8
120	36-50	M	P	AD		3-6	NSB RP	S	O	4	6
121	26-35	M	P	BS	X	0-3	NSB ASB SBD CS C RP	S	O	5	6
122	25 ≤	M	P	BS	X	0-3	NSB CS C RP	S	SO	5	5
123	36-50	M	C	AD		0-3	NSB ASB	O	O	7	8
124	26-35	M	P	AD		0-3	SBD RP	O	O	4	8
125	26-35	M	P	AD		0-3	NSB ASB RP	SO	O	6	8
126	36-50	M	P	BS		6-10	RP	O	O	3	6
127	26-35	M	P	AD		6-10	NSB ASB SBD CS C RP	O	O	4	8
128	51 ≥	M	P	D		> 10	RP	SO	O	4	5
129	26-35	M	P	BS		0-3	NSB RP	S	O	7	9
130	26-35	M	P	AD		> 10	NSB ASB SBD CS C RP	O	O	3	7
131	26-35	M	P	AD		0-3	NSB CS C RP	N	O	3	4
132	26-35	D/S	O	AD		3-6	NSB ASB SBD CS C RP	S	O	8	7
133	25 ≤	M	P	AD	X	0-3	NSB SBD CS C RP	O	O	4	7
134	26-35	M	P	AD		3-6	C RP	SO	O	4	8
135	36-50	M	P	D		3-6	NSB ASB SBD CS C RP	S	O	5	9
136	51 ≥	M	P	D		0-3	RP	S	S	5	6
137	36-50	M	P	D		3-6	NSB C RP	O	O	4	8
138	26-35	M	P	AD		3-6	RP	O	O	6	7
139	51 ≥	M	P	D		> 10	RP	S	SO	4	9

the first null hypothesis. These data can be found in Table 2.

Table 2

A Biserial Correlation of Nurses' Educational Levels and Attitude Scores on the Adolescent Knowledge and Attitude Questionnaire

Educational Level	n	r
Diploma	55	-.0781
Associate degree	62	.1023
Baccalaureate degree	20	-.0062
Additional college	2	.0874
Total	139	

Comparison of the educational levels and knowledge scores revealed values of .2321 for diploma degrees, .2292 for associate degrees, .1245 for baccalaureate degrees, and .0846 for additional college degrees. There was significance at the .05 level in the diploma and associate degree categories. This indicates that nurses with diploma degrees had lower knowledge scores and nurses with associate degrees had higher knowledge scores. Thus, the researcher rejected the second null hypothesis. These data can be found in Table 3.

Table 3

A Biserial Correlation of Nurses' Educational Levels and Knowledge Scores on the Adolescent Knowledge and Attitude Questionnaire

Educational Level	n	r
Diploma	55	-.2321*
Associate degree	62	.2292*
Baccalaureate degree	20	.1245
Additional college	2	-.0846
Total	139	

*$p \leq .05$.

Additional Findings

To further examine the relationships between the demographic data and the knowledge scores, the Biserial Correlation was again used at the .05 level of significance. The variables of age, curriculum on concepts of sexuality, and curriculum on contraception were correlated with knowledge scores. There was a negative correlation between age and knowledge scores with a significant r value of .1522 for curriculum on contraception when compared to knowledge scores. However, an r value of .1279 indicated no significance when curriculum on concepts of sexuality was

compared to knowledge scores. These data suggest that older PHNs have less knowledge about adolescent sexuality and PHNs who had curriculum on contraception have more knowledge. These data can be found in Table 4.

Table 4

A Biserial Correlation of Nurses' Demographic Variables and Knowledge Scores on the Adolescent Knowledge and Attitude Questionnaire

Variable	N	r
Age	139	-.2132*
Curriculum on concepts of sexuality	139	.1279
Curriculum on contraception	139	.1522*

*$p \leq .05$.

The variables experience, curriculum on abnormal sexual behavior, curriculum on concepts of sexuality, and curriculum on contraception were correlated with attitude scores using the Biserial Correlation at the .05 level of significance. There was a negative correlation between years of experience and attitude scores with a significant r value of -.2131. There were also significant r values of .1676 for curriculum on abnormal sexual behavior, .1719 for curriculum on concepts of sexuality, and .1892 for curriculum on

contraception. These data suggest that PHNs with 10 or more years of experience have more conservative attitudes about adolescent sexuality than nurses with less experience. Additionally, PHNs who have had curricula on abnormal sexual behavior, concepts of sexuality and contraception seem to have more liberal attitudes about adolescent sexuality. Table 5 presents these findings.

Table 5

A Biserial Correlation of Nurses' Demographic Variables and Attitude Scores on the Adolescent Knowledge and Attitude Questionnaire

Variable	N	r
Age	139	-.2131
Curriculum on abnormal sexual behavior	139	.1676*
Curriculum on concepts of sexuality	139	.1719*
Curriculum on contraception	139	.1892*

*$p \leq .05$.

The researcher observed weaknesses in the tool used in this study. There was not a demographic question on the tool to indicate the races of the subjects; therefore, the sample may not have been representative of all races. More

questions should have been included in the tool to measure knowledge and attitudes. This would have increased the tool's validity.

Chapter VII

Summary, Conclusions, Implications, and Recommendations

Summary

This descriptive study was designed to determine the need for education about adolescent sexuality for public health nurses (PHNs) in Mississippi. Two null hypotheses were stated. Hypothesis I stated that when the nurses' levels of education and attitude scores on the Adolescent Knowledge and Attitude Questionnaire were correlated, there would be no significant correlations at the .05 level. Hypothesis II stated that when the nurses' levels of education and knowledge scores on the Adolescent Knowledge and Attitude Questionnaire were correlated, there would be no significant correlations at the .05 level.

Data were collected from 139 subjects who completed the Adolescent Knowledge and Attitude Questionnaire. The nurses' scores on the survey were correlated with their levels of education utilizing the Biserial Correlation coefficient at the .05 level of significance.

The results demonstrated no significant correlation between the educational levels and the attitude scores; however, there were significant correlations between diploma

and associate degree levels and knowledge scores. Therefore, the researcher failed to reject null Hypothesis I and rejected null Hypothesis II.

Conclusions and Implications

The data from the study indicate that no significant correlation exists between the nurses' levels of education and their attitudes about adolescent sexuality; however, there were significant correlations between the nurses who had specific content in their educational programs which dealt with human sexuality and their attitudes as well as their knowledge about adolescent sexuality. These findings support Luber (1975) who found that the more knowledge a nurse has of sexuality, the more favorable her attitude toward sexuality. These findings also support de Lemos (1977) who reported changes in sexual knowledge and attitudes following a three-day sexuality workshop.

Additional significant correlations were found between the PHN's level of education and her knowledge about adolescent sexuality, and between the PHN's years of experience and her attitudes about adolescent sexuality. Diploma degree nurses tended to be less knowledgeable and associate degree nurses tended to be more knowledgeable. PHNs who were 51 years old or older were less knowledgeable than PHNs who were younger. Nurses with 10 or more years of experience had more conservative attitudes than those with less experience.

These findings have implications for the FNC as a leader in primary health care. The FNC should become involved in developing, conducting, and evaluating educational programs and workshops on adolescent sexuality for all PHNs regardless of age, years of experience, and educational backgrounds of the PHNs. The FNC should also communicate the need for specific curricula on aspects of human sexuality in schools of nursing.

This researcher observed weaknesses in the Adolescent Knowledge and Attitude Questionnaire used in this study. Races of the subjects could not be identified with this tool; therefore, the sample may not have represented all races of PHNs. The tool would have been more valid if more questions were added to measure the PHN's knowledge and attitudes. Additionally, more pretesting of the tool is needed to validate these changes.

Recommendations

The researcher recommends:

Research

1. Revision of the tool to include more knowledge questions specific to adolescent sexuality.

2. Revision of the tool to include more attitude questions specific to adolescent sexuality.

3. Revision of the tool to include an indication of race among the demographic data.

4. Replication of the study using the revised tool.

Nursing

1. Involvement in developing, conducting, and evaluating educational programs and workshops on adolescent sexuality for all PHNs.

2. Inclusion of specific content on aspects of human sexuality in schools of nursing.

Appendix A

Institution's Memorandum of Agreement Concerning Public Health Nurses' Knowledge and Attitudes of Adolescent Sexuality

Title of Study: Mississippi Public Health Nurses' Attitudes and Knowledge About Adolescent Sexuality

_____
Name of Institution

Study discussed with and explained to:

_____
Name of Representative

Involvement in Study:

Cooperation:

1. Consent for researcher to administer by mail a questionnaire on adolescent sexuality to public health nurses.
2. Consent for researcher to obtain list of currently practicing public health nurses.

Comments:

_____

_____

_____ _____
Date Signature of Representative

_____
Researcher

Appendix B

Letter of Explanation

421 Glen Rose Drive
Jackson, Mississippi 39209
March 18, 1985

Dear _____:

My name is Charlotte Peavie. I am a graduate student at Mississippi University for Women. I am presently conducting a survey about public health nurses' knowledge and attitudes regarding adolescent sexuality. It would be most helpful if you would agree to participate in my study by completing the enclosed questionnaire and sending it back to me in the enclosed self-addressed, stamped envelope. It is understood that return of this questionnaire will be considered informed consent. Your anonymity will be protected as no names will appear on the questionnaire.

I realize the demands of your time are great, but I believe that the results of this study will help determine what areas related to adolescent sexual counseling need reinforcement. Your participation will be greatly appreciated. Please return the survey within two weeks.

Thank you.

Gratefully,

Charlotte Peavie, R.N., C.

Appendix C

Adolescent Knowledge and Attitude Questionnaire

Instructions: Answer each question carefully. Please make sure you do not skip any questions. To indicate your answers, circle the letter beside the response you wish to indicate. In the case of the true-false questions, circle the entire word true or false beside each statement to indicate your response.

1. Age:

    a. 25 or younger
    b. 26-35
    c. 36-50
    d. 51 or older

2. Marital status:

    a. Married
    b. Never married
    c. Divorced or separated
    d. Widowed

3. Childhood religious background:

    a. Protestant
    b. Catholic
    c. Jewish
    d. Other

4. Educational background: Circle all appropriate responses.

    a. Diploma degree
    b. Associate degree
    c. Baccalaureate
    d. Additional college degree(s) other than master's degree
    e. Master's degree
    f. Human sexuality course(s) in past 2 years

5. Years of public health nursing experience:

   a. 0-3
   b. 3-6
   c. 6-10
   d. More than 10

6. Did your school of nursing have specific curriculum for any of the following subjects? Circle all appropriate responses.

   a. Normal sexual behavior
   b. Abnormal sexual behavior
   c. Sexual behavior in relation to any disease or physical condition
   d. Concepts of sexuality
   e. Contraception
   f. Reproductive processes

7. How often have you been asked questions regarding sexual behavior by adolescent clients? Circle one answer only.

   a. Never
   b. Seldom
   c. Sometimes
   d. Often

8. How often have you answered an adolescent client's questions regarding contraception? Circle one answer only.

   a. Never
   b. Seldom
   c. Sometimes
   d. Often

9. In general, do you see adolescent sexual counseling within the realm of any of the following professionals? Circle all appropriate responses.

   a. Physicians
   b. Nurses
   c. Psychiatrists or psychologists
   d. Social workers
   e. Clergy
   f. None of the above

10. How do you think you would feel about asking adolescent clients about their sexual problems? Circle <u>one</u> answer only.

    a. At ease
    b. Somewhat apprehensive
    c. Apprehensive
    d. Too apprehensive to try

11. Adolescents are a difficult group to counsel. Circle <u>one</u> answer only.

    a. Never
    b. Seldom
    c. Sometimes
    d. Often

12.	True	False	Homosexual behavior is immoral.
13.	True	False	Masturbation is common and normal behavior for adolescents.
14.	True	False	Abortion is only acceptable in order to save the life of the mother.
15.	True	False	There are two kinds of physiological responses in women, one clitoral, and the other vaginal.
16.	True	False	Intercourse among nonmarried adolescents is wrong under any circumstances.
17.	True	False	Masturbation may lead to mental illness.
18.	True	False	Oral-genital sex is acceptable behavior.
19.	True	False	<u>Blue balls</u> is a term used to describe a temporary discomfort experienced when penile erection does not progress to ejaculation.
20.	True	False	During middle adolescence, decisions about sexuality are made with little regard to the opinions of others.
21.	True	False	Adolescents are often preoccupied with their body images.

22.	True	False	In the clinical assessment of the adolescent client's level of peer relationship, it is important to ask about friends.
23.	True	False	The individual growth curves of most adolescents are normally not very smooth.
24.	True	False	During stage II of the sexual development of males, nocturnal emissions usually begin.
25.	True	False	Breast development usually begins during stage III of female sexual development.
26.	True	False	Adolescents should make their own decisions regarding active sexual participation.
27.	True	False	Homosexual adolescents should be persuaded to change their sexual preference.
28.	True	False	Adolescent boys should be given basic knowledge about menstruation.

References

Alan Guttmacher Institute. (1981). Teenage pregnancy: The problem that hasn't gone away. New York: A.G.I. Publications.

Barnett, D. (1984). The tragedy of unplanned babies. Mississippi's Health, 1(2), 6-7.

Bradshaw, B. R., Wolfe, W. M., Wood, T. J., & Tyler, L. S. (1977). Counseling on family planning and human sexuality. New York: Family Service Association of America.

Congressional Research Service. (1984, March). Infant mortality. Washington, DC: U.S. Government Printing Office.

de Lemos, H. (1977). Changes in helping professionals; knowledge and attitudes following a human sexuality workshop led by a nurse. JPN and Mental Health Services, 15(7), 11-21.

Dacey, J. S. (1979). Adolescents today. Santa Monica, CA: Goodyear Publishing Company.

Falvo, D., Woehlke, P., & Deichmann, J. (1980, Fourth Quarter). Relationship of physician behavior to patient compliance. Patient Counselling and Health Education, 185-188.

Fisher, S. G., & Levine, D. L. (1983). The sexual knowledge and attitudes of professional nurses caring of oncology patients. Cancer Nursing, 6(1), 55-61.

Fontaine, K. L. (1976). Human sexuality: Faculty knowledge and attitudes. Nursing Outlook, 24(3), 174-176.

George, J. B. (1980). Imogene M. King. In J. B. George (ed.), Nursing theories: The base for professional nursing practice (pp. 184-197). New Jersey: Prentice-Hall.

Hill, M. F., & Ricks, E. L. (1984). Teenage pregnancy prevention: An Atlanta program. Urban Health, 3(1), 26-29.

Igoe, J. B. (1980). Health counseling and teaching. In J. Howe (Ed.), Nursing care of adolescents (pp. 323-340). New York: McGraw-Hill.

King, I. M. (1971). Toward a theory for nursing: General concepts of human behavior. New York: John Wiley & Sons.

King, I. M. (1981). A theory for nursing: Systems, concepts, process. New York: John Wiley & sons.

King, I. M. (1983). King's theory of nursing. In I. W. Clements & F. B. Roberts (Eds.), Family health: A theoretical approach to nursing care (pp. 177-188). New York: John Wiley & Sons.

Lief, H. I., & Payne, T. (1975). Sexuality knowledge and attitudes. American Journal of Nursing, 75(11), 2026-2029.

Luber, T. (1975). Sexuality of nurses: Correlations of knowledge, attitudes, and behavior. Nursing Outlook, 25(4), 286-292.

Maslach, G., & Kerr, G. B. (1983). Tailoring sex education programs to adolescents: A strategy for the primary prevention of unwanted adolescent pregnancies. Adolescence, 18(70), 449-456.

Mims, F. H. (1975). Sexual health education and counseling. Nursing Clinics of North America, 10(3), 519-528.

Mississippi Statistical Abstract. (1984). Rowland Medical Library, University of Mississippi Medical Center, p. 162.

Mississippi State Department of Health. (1984). Public health statistics. Jackson, MS: Author.

Nicholson, B., Lord, K., Tibbett, P., & Borningham, J. (1981). Professional attitudes of RN's to human sexuality. The Australian Nurses' Journal, 11(5), 51-53.

Onyehalu, A. S. (1983). Inadequacy of sex knowledge of adolescence: Implications for counseling and sex education. Adolescence, 18(71), 627-630.

Polit, D. F., & Hungler, B. P. (1983). Nursing research: Principles and methods (2nd ed.) (p. 613). Philadelphia, PA: J. B. Lippincott.

Reagan, P. (1981, First Quarter). The interaction of health professionals and their lesbian clients. Patient Counseling and Health Education, 21-25.

Robinson, P. (1984). The effects of a teaching session on public health nurses' knowledge and attitudes toward adolescent sexuality. Unpublished master's thesis, Mississippi University for Women, Columbus, MS.

Schuster, E. A., Unsain, I. C., & Goodwin, M. H. (1982). Nursing practice in human sexuality. Nursing Clinics of North America, 17(3), 345-349.

Smith, J. A. (1984). Sex counseling: Reaching teenagers in time to prevent trouble. Consultant, 7(1), 155-161.

Strecher, V. J. (1984). Improving physician-patient interactions: A review. Patient Counseling and Health Education, 4(3), 129-135.

Taver, K. (1983). Promoting effective decision-making in sexually active adolescents. Nursing Clinics of North America, 6(1), 275-291.

Zalar, M. K. (1982). Role preparation for nurses in human sexual functioning. Nursing Clinics of North America, 17(3), 351-361.

Ward, M., & Lindeman, C. (Eds.). (1975). Instruments for measuring nursing practice and other health care variables (Vol. 1, pp. 16-21). Rockville, MD: U.S. Department of Health, Education, and Welfare.

Zakus, G., Cooper, H., Leff, M., & Moore, V. (1980). Clinical assessment of the adolescent patient. Journal of Family Practice, 7(1), 9-21.